Southern Cardiovascular Care, PC

1800 Fairview Avenue, Suite 1
Dothan, AL 36301
Phone: 334 699-8900
Fax: 334 699-7498

Referral Form

Date: ___/___/___

Please use the form to ensure **ALL REQUIRED** documents are received. **Thank you for your referral**!

Patient Information Name : _____

Date of Birth:_____ Age:_____ Gender: M F SSN#:_____

Address: _____

Phone#: Home (____) _____-_____ Mobile (_____) _____-_____ Work (____) _____-_____

Reason for referral:_____ Diagnosis:_____

******REQUIRED CLINICAL INFORMATION TO PROCESS THIS REFERRAL******

Recent H & P ECG ECHO CAROTID US Stress Test Results

MRI CT Cardiac Catheterization /intervention reports Operative reports for Cardiac Procedures within last 5 years

List of current medications:

Referring MD: _____ Specialty: _____

Address: _____ _____

Phone #: (__)_____ FAX #: (____)_____ _____

PCP: _____

Address:_____

Phone# (_____) _____ FAX#(_____) _____

Insurance Information : If patient has HMO plan, they must provide copy of referral authorization prior to first appointment.

Name of the insured: _____ Policy# _____ Group# _____

Has the insurance company been notified of referral? YES ☐ NO ☐

Authorization #: _____

TO BE FILLED OUT BY SOUTHERN CARDIOVASCULAR CARE, PC

MR#: _____ APPOINTMENT DATE: _____ TIME: _____
REFFERAL#:_____
COMENTS:_____
_____

Specializing in Comprehensive Heart and Cardiovascular Care